MEDI-CAL UPDATE Part 2
Billing and Policy
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Inpatient Services

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Contents

2006 CPT-4/HCPCS Updates: Implementation November 1, 2006

The 2006 updates to the *Current Procedural Terminology – 4th Edition* (CPT-4) and Healthcare Common Procedure Coding System (HCPCS) National Level II codes will be effective for Medi-Cal for dates of service on or after November 1, 2006. Specific policy changes are detailed below. Updated manual replacement pages reflecting the policy changes will be published in a future *Medi-Cal Update.*

MEDICINE

Deleted and Replacement Codes

The following are deleted CPT-4 codes and their replacement codes. The policy of the deleted code applies to the replacement codes.

Deleted Code(s)	Replacement Code(s)
90780, 90781	90760, 90761, 90765 – 90768
90799	90772, 90779
96100	96101
96115	96116
96117	96118
96400	96401, 96402
96408	96409
96410	96413
96412	96415
96414	96416
96520	96521
96530	96522
99301 – 99303	99304 – 99306
99311 – 99313	99307 – 99309
99321 – 99323	99234 – 99236
99331 – 99333	99334 – 99336

Billing Restrictions

Codes 58110, 82271, 92626, 92627, 92630, 92633, 96101, 96116, 96118, 96521 and 96522 are classified as common office procedures. Reimbursement for these codes will be cut back to 80 percent of the reimbursement amount when performed in an emergency room or outpatient hospital setting.

Claims for CPT-4 codes 90760 (hydration, first hour) and 90765 (IV infusion, first hour) must include documentation that the physician personally administered or directly supervised the infusion therapy.

Claims for CPT-4 codes 90761 (hydration, each additional hour) and 90766 (IV infusion, each additional hour) must include medical justification when billed for more than one additional hour. The maximum allowed is eight additional hours.

Claims for CPT-4 codes 90767 and 90768 must include documentation to justify the need for concurrent or sequential infusion.

Please see **CPT-4/HCPCS**, *page 2*

CPT-4/HCPCS *(continued)*

Reimbursement for any combination of codes 95860 – 95875 (electromyography) is limited to four times per year. Medical justification for additional services must be documented in the *Remarks* area of the claim. These services are reimbursable only to providers who have a diploma or certificate of completion of an accredited neurology or physical medicine and rehabilitation residency program.

Claims for CPT-4 codes 96101 (psychological testing), 96116 and 96118 (neuropsychological testing) must include a report that documents the results of the specific assessments and/or tests.

Claims for code 96415 (chemotherapy IV infusion, each additional hour) require medical justification if billed for more than one hour. The maximum additional hours allowed is eight.

Codes 99143, 99144, 99148 and 99149 (conscious sedation) are exempt from the 50 percent multiple surgery cutback when billed with modifier -51.

Codes 99145 and 99150 (conscious sedation) require medical justification if billed for more than two units (30 minutes).

CPT-4 codes 99304, 99307 – 99309, 99324 – 99326 and 99334 – 99336 are reimbursable to podiatrists.

Add-On Codes

The following CPT-4 codes are add-on codes and must be billed on the same claim with the corresponding code for the primary procedure:

Add-On Code	Primary Procedure Code(s)
15111	15110
15116	15115
15131	15130
15136	15135
15151 *	15150
15152	15151
15156 *	15155
15157	15156
15171	15170
15176	15175
15301	15300
15321	15320
15331	15330
15336	15335
15341	15340
15361	15360
15366	15365
15421	15420
15431	15430
22525	22523, 22524
31620	31622 – 31646
33768	33478, 33617, 33767
33884	33883
33924	33470 – 33475, 33600 – 33619, 33684 – 33688, 33692 – 33697, 33735 – 33767, 33770 – 33781, 33786, 33920 – 33922
44213	44204 – 44208
58110	57420, 57421, 57454 – 57461
61641, 61642	61640
83901	83900
90761	90760

Please see **CPT-4/HCPCS**, *page 3*

CPT-4/HCPCS *(continued)*

Add-On Codes (continued)

Add-On Code	Primary Procedure Code(s)
90766	90765, 90767
90767	90765, 90774, 96409, 96413 **
90768	90765, 96413
92627	92626
93662	92987, 93527, 93532, 93580, 93581, 93621, 93622, 93651, 93652
95873, 95874	64612 – 64614
96411	96409, 96413
96415, 96417	96413
99145	99143, 99144
99150	99148, 99149
99356	99221 – 99233, 99251 – 99255

All of the add-on codes listed above are exempt from the multiple surgery cutback when billed with modifier -51.

* Reimbursement for codes 15151 and 15156 are limited to once per session, same provider. Claims for more than once per day must include a statement in the *Remarks* area that the procedure was not performed during the same session.

** When performed as a secondary or subsequent service.

The manual replacement pages reflecting these policies will be released in the October *Medi-Cal Update.*

2007 ICD-9 Procedure Code Updates for Inpatient Providers

The following ICD-9 procedure code updates are effective for dates of service on or after October 1, 2006, for Inpatient providers only. Providers must bill using the highest level of specificity.

New ICD-9 Procedure Codes

ICD-9 Code	Description
00.44	Procedure on vessel bifurcation
00.56	Insertion or replacement of implantable pressure sensor (lead) for intracardiac hemodynamic monitoring
00.57	Implantation or replacement of subcutaneous device for intracardiac hemodynamic monitoring
00.77	Hip replacement bearing surface, ceramic-on-polyethylene
00.85	Resurfacing hip, total, acetabulum and femoral head
00.86	Resurfacing hip, partial, femoral head
00.87	Resurfacing hip, partial, acetabulum
01.28	Placement of intracerebral catheter(s) via burr hole(s)
13.90	Operation on lens, not elsewhere classified
13.91	Implantation of intraocular telescope prosthesis
32.23	Open ablation of lung lesion or tissue
32.24	Percutaneous ablation of lung lesion or tissue
32.25	Thoracoscopic ablation of lung lesion or tissue
32.26	Other and unspecified ablation of lung lesion or tissue
33.71	Endoscopic insertion or replacement of bronchial valve(s)
33.78	Endoscopic removal of bronchial device(s) or substances
33.79	Endoscopic insertion of other bronchial device or substances

Please see **2007 ICD-9 Procedure Codes**, *page 4*

2007 ICD-9 Procedure Codes *(continued)*

New ICD-9 Procedure Codes (continued)

ICD-9 Code	Description
35.55	Repair of ventricular septal defect with prosthesis, closed technique
36.33	Endoscopic transmyocardial revascularization
36.34	Percutaneous transmyocardial revascularization
37.20	Noninvasive programmed electrical stimulation (NIPS)
39.74	Endovascular removal of obstruction from head and neck vessel(s)
50.23	Open ablation of liver lesion or tissue
50.24	Percutaneous ablation of liver lesion or tissue
50.25	Laparoscopic ablation of liver lesion or tissue
50.26	Other and unspecified ablation of liver lesion or tissue
55.32	Open ablation of renal lesion or tissue
55.33	Percutaneous ablation of renal lesion or tissue
55.34	Laparoscopic ablation of renal lesion or tissue
55.35	Other and unspecified ablation of renal lesion or tissue
68.41	Laparoscopic total abdominal hysterectomy
68.49	Other and unspecified total abdominal hysterectomy
68.61	Laparoscopic radical abdominal hysterectomy
68.69	Other and unspecified radical abdominal hysterectomy
68.71	Laparoscopic radical vaginal hysterectomy (LRVH)
68.79	Other and unspecified radical vaginal hysterectomy

Revised ICD-9 Procedure Codes

01.26	Insertion of catheter(s) into cranial cavity or tissue
01.27	Removal of catheter(s) from cranial cavity or tissue
35.53	Repair of ventricular septal defect with prosthesis, open technique
37.26	Catheter based invasive electrophysiologic testing
68.39	Other and unspecified subtotal abdominal hysterectomy
68.59	Other and unspecified vaginal hysterectomy

Deleted ICD-9 Procedure Codes

13.9	Other operations on lens
68.4	Total abdominal hysterectomy
68.6	Radical abdominal hysterectomy
68.7	Radical vaginal hysterectomy

This information is reflected on manual replacement pages hyst 3 and 4 (Part 2).

Primary Diagnosis Code Changes for GHPP Claims

Effective September 1, 2006, claims for reimbursement of Genetically Handicapped Persons Program (GHPP) services may be billed with a primary diagnosis code that reflects the condition for which the client seeks medical help. Previously, the primary diagnosis was limited to the ICD-9 code for the condition that qualified the client to participate in the Genetically Handicapped Persons Program.

For example, under the new policy if a client qualifies for GHPP due to cystic fibrosis (ICD-9 code 277.0) but presents to the doctor with the flu (ICD-9 code 487), then the code for the presenting condition would be entered as the primary diagnosis code. The code for cystic fibrosis would be entered as a secondary diagnosis.

This information is reflected on manual replacement pages genetic 5 and 6 (Part 2).

2007 ICD-9 Diagnosis Code Update

The following diagnosis code additions, inactivations and revisions are effective for claims with dates of service on or after October 1, 2006. Providers may refer to the *2007 International Classification of Diseases, 9th Revision, Clinical Modifications, 6th Edition* for ICD-9 code descriptors.

Additions
The following ICD-9 diagnosis codes are new:

052.2	053.14	054.74	238.71
238.72	238.73	238.74	238.75
238.76	238.79	277.30	277.31
277.39	284.01	284.09	284.1
284.2	288.00	288.01	288.02
288.03	288.04	288.09	288.4
288.50	288.51	288.59	288.60
288.61	288.62	288.63	288.64
288.65	288.69	289.53	289.83
323.01	323.02	323.41	323.42
323.51	323.52	323.61	323.62
323.63	323.71	323.72	323.81
323.82	331.83	333.71	333.72
333.79	333.85	333.94	338.0
338.11	338.12	338.18	338.19
338.21	338.22	338.28	338.29
338.3	338.4	341.20	341.21
341.22	377.43	379.60	379.61
379.62	379.63	389.15	389.16
429.83	478.11	478.19	518.7
519.11	519.19	521.81	521.89
523.00	523.01	523.10	523.11
523.30	523.31	523.32	523.33
523.40	523.41	523.42	525.60
525.61	525.62	525.63	525.64
525.65	525.66	525.67	525.69
526.61	526.62	526.63	526.69
528.00	528.01	528.02	528.09
538	608.20 *	608.21 *	608.22 *
608.23 *	608.24 *	616.81 **	616.89 **
618.84 **	629.29 **	629.81 ** +	629.89 **
649.00 ** +	649.01 ** +	649.02 ** +	649.03 ** +
649.04 ** +	649.10 ** +	649.11 ** +	649.12 ** +
649.13 ** +	649.14 ** +	649.20 ** +	649.21 ** +
649.22 ** +	649.23 ** +	649.24 ** +	649.30 ** +
649.31 ** +	649.32 ** +	649.33 ** +	649.34 ** +
649.40 ** +	649.41 ** +	649.42 ** +	649.43 ** +
649.44 ** +	649.50 ** +	649.51 ** +	649.53 ** +
649.60 ** +	649.61 ** +	649.62 ** +	649.63 ** +
649.64 ** +	729.71	729.72	729.73
729.79	731.3	768.70 #	770.87 #
770.88 #	775.81 #	775.89 #	779.85 #
780.32	780.96	780.97	784.91
784.99	788.64	788.65	793.91
793.99	795.06 **	795.81	795.82
795.89	958.90	958.91	958.92
958.93	958.99	995.20	995.21

Please see **ICD-9 Diagnosis Code Update**, *page 6*

ICD-9 Diagnosis Code Update *(continued)*

Additions (continued)

995.22	995.23	995.27	995.29
V18.51	V18.59	V26.34 *	V26.35 *
V26.39 *	V45.86	V58.30	V58.31
V58.32	V72.11	V72.19	V82.71
V82.79	V85.51	V85.52	V85.53
V85.54	V86.0 ** +	V86.1 ** +	

Restrictions

* Restricted to males only
** Restricted to females only
# Restricted to ages 0 thru 1 year
\+ Restricted to ages 10 thru 99

Inactive Codes

Effective for dates of service on or after October 1, 2006, the following ICD-9 diagnosis codes are no longer reimbursable:

238.7, 277.3, 284.0, 288.0, 323.0, 323.4, 323.5, 323.6, 323.7, 323.8, 333.7, 478.1, 519.1, 521.8, 523.0, 523.1, 523.3, 523.4, 528.0, 608.2, 616.8, 629.8, 775.8, 784.9, 793.9, 995.2, V18.5, V58.3, V72.1

Code Description Revisions

The descriptions of the following ICD-9 diagnosis codes are revised:

255.10, 285.29, 323.1, 323.2, 323.9, 333.6, 345.40, 345.41, 345.50, 345.51, 345.80, 345.81, 389.11, 389.12, 389.14, 389.18, 403.00, 403.01, 403.10, 403.11, 403.90, 403.91, 404.00, 404.01, 404.02, 404.03, 404.10, 404.11, 404.12, 404.13, 404.90, 404.91, 404.92, 404.93, 524.21, 524.22, 524.23, 524.35, 600.00, 600.01, 600.20, 600.21, 600.90, 600.91, 780.31, 780.95, 790.93, 873.63, 873.73, 995.91, 995.92, 995.93, 995.94, V26.31, V26.32

Instructions for Manual Replacement Pages — Part 2

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Remove and replace: genetic 5/6
hyst 3/4